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Metropolitan Transportation Authority
State of New York

July 26, 2007

Mr. Daniel J. Bruno
137 Overlook Drive
Mahopac, NY 10541-3672

Dear Mr. Bruno:

I am writing you with regard to your application for an Accidental Disability Retirement under the MTA 20 Year Police Retirement Program and our letter of January 11, 2007.

Based on the recommendation of the Medical Board (copy attached), your application is denied.

Should you have any questions concerning this pension application, contact the MTA Pension Office at (212) 878-7004.

Sincerely,

Barbara A. Roche
Director, Consolidated Pensions

c: Philip J. Dinhofer, Esq.

Bruno, Daniel

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July 25, 2007

Barbara Roche
Director, Consolidated Pensions
347 Madison Avenue
New York, NY 10017

Re: Accidental Disability Retirement - Daniel Bruno; Addendum to Medical Board letter of December 07, 2006.

Dear Ms. Roche:

This addendum report is in reference to the application filed by Daniel Bruno, a 36-year-old Police Officer with the Metropolitan Transportation Authority for Accidental Disability Retirement.

CASE HISTORY

The Medical Board is in receipt of a letter dated March 25, 2007 regarding the disability pension of MTA Police Officer Daniel Bruno from Philip J. Dinhofer, Esq. It would appear that based upon the letter of Mr. Dinhofer these documents came directly from his office. The Medical Board received and reviewed 1,312 pages of information, some of which was new since the previous Board meeting of September 6, 2006. There were many duplicate records which were previously reviewed as well as duplicate records of new information.

The following were listed in Mr. Dinhofer's letter:

1. Transcript Trial Testimony of Kishore Ranade, M.D.
2. Office records of Kishore Ranade, M.D.
3. Office records of A. K. Chaudhry, an internist.
4. Office records of Jeffrey M. Binder, M.D.
5. Office records of Jeffrey Kleinbaum, M.D.
6. Office records of Alan Coffino, M.D.
7. Office records of Anup Das, M.D.
8. Office records of Eric Teitel, M.D.,
9. Office records of Jerry Green, M.D.
10. Office records of Jerry Yormak, M.D., an orthopedist.
11. Hudson Valley Hospital records.
12. Putnam Hospital records.
13. Northeast Radiology records.
14. New York Central Mutual Insurance Company No-Fault records.
15. Quest Diagnostic Laboratory reports.
16. Labcor reports.

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17. Records from Datahr Rehabilitation.

These are Bates numbered from 000001 to 001312 and are listed on the cover letter of Philip J. Dinhofer dated March 25, 2007. The entire 1,312 pages were reviewed by the Board.

Medical Board comments on the medical documentation preceding the incident of September 22, 2003:

1. The emergency department record from Putnam Hospital Center dated September 6, 2003. This precedes the incident of September 22, 2003 by two and a half weeks. The applicant presented that day with sore throat for six weeks and difficulty swallowing, joint pain, and headache. He was afebrile at that time. Laboratory values were abnormal. This included an anemia with hemoglobin of 12, hematocrit of 35.3, an MCV of 105, and MCH of 35.8 indicating a macrocytic anemia (Bates #962-969).
2. There were laboratory records of blood chemistries of September 18, 2003 which noted sodium of 138. The abnormalities included elevated urea nitrogen of 26 and a BUN and creatinine ratio of 32.5 (Bates # 352).
3. The Medical Board also reviewed laboratory records dated May 9, 2000 more than a year preceding the incident and notes laboratory abnormalities of sodium of 132 millimoles representing hyponatremia and a chloride was abnormal at 96 (Bates # is illegible).
4. There is an abnormal glucose laboratory result on October 10, 2002. The glucose was 56 which is low (Bates #345).
5. There are medical records beginning with a notation preceding a September 18, 2003 visit which indicates that Viagra 50 mg sample... (remainder is illegible). (Bates #410 to 412)
6. There is a laboratory result of free testosterone being low which was drawn on September 18, 2003. The level is 36.5 (Bates #532).
7. There are medical records from PHC Emergency Department which indicate a work up for ehrlichiosis and a Lyme's immunology which was equivocal. ELISA was within normal limits dated September 6, 2003.
8. There is a neuropsychological evaluation with the date of report December 13, 1999 summarizing dates of service including November 5, 1999, November 27, 1999, and December 10, 1999. In these notes, there are a number of reports underlying cognitive difficulties. They stated he has noticed a number of problems since the 1998 incident. For instance, there were speech difficulties noted particularly with confusion with the order of his verbal expression. He notes his reading ability is improved, but his writing ability continues to feel odd (Bates #240 to 246). Conclusion on page 246 in which he stated he is a candidate for cognitive remediation.
9. There is a notation which is unsigned indicating that Mr. Bruno was seen for neurological follow up. At that time, he indicates the patient remained disabled until March 2000. He notes he is only able to drive short distances and eye tracking movements makes him severely dizzy (Bates #239).

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10. On December 10, 1999, Dr. Ranade indicated persistent post-concussive syndrome with continuous symptoms of memory dysfunction, dizziness, disorientation on multi-task processing (Bates # 211).
11. On June 8, 2000, Dr. Jeffrey L. Benjamin notes he is much improved status post motor vehicle accident and wishes to return to work as a police officer. He notes the patient has significantly improved and awaiting final notes from Datahr regarding his neurocognitive status (Bates # 206).
12. There is a discharge summary dated June 2, 2000 from Datahr Rehabilitation which notes he has received maximal benefit. Despite significant improvement, they note "his verbal skills have improved with occasional efforts noted in mispronouncing words, he knows to use the strategy or slowing down his rate of speech." He notes Mr. Bruno's auditory and comprehension for long complex information has improved with him taking more notes and requiring less repetition of information. He also notes an ability to shift attention between tasks has also increased." He should continue to use his strategies to maintain his level of functioning in a variety of settings." (Bates # 207).

Medical Board comments on the medical documentation following the incident of September 22, 2003:

1. There is an emergency department record of September 27, 2003, from Putnam Hospital noting a presentation of flu-like symptoms with headache and photophobia, fevers, chills, and body aches. There was also the complaint of nausea, vomiting, and diarrhea. The temperature was 99.5. Diagnoses were fever, headaches, malaise, Lyme's disease, ehrlichiosis, and a head injury with unspecified conscious state. Neurologic examination noted and he was alert and oriented x3. There was a consultation by Dr. Ranada who doubted that the patient had meningitis; also noted a mild concussion, rule out bleed. Systemic work-up for sepsis was ordered by Dr. Kurtz. Dr. Ranada noted that the police officer presented following a pipe striking the back of his head at work, without loss of consciousness. He subsequently had fever at home with no chills, no decreased mentation, or seizures and that was he was being worked up for hematologic problem. He found no lethargy, delirium, or confusion and essentially normal motor and sensory examination without neck stiffness. Laboratory evaluation noted hemoglobin of 12.2, hematocrit of 35.3, which is abnormal and indicative of anemia. At that time, his sodium was 125 mEq per liter (low); the remainder of laboratories was within normal limits. (Bates# 986-990) CAT scan on that day was also normal (page #99 ?)

2. There are progress notes dated December 9, 2003 from Oxford Medical Group. This notes a referral and the record indicates "7-9/2003, lethargy/decreased energy." It also notes that he was treated with a course of doxycycline for ehrlichiosis and was diagnosed with chickenpox on October 3 and has been treated for four to five weeks (page #445).

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3. There were progress notes of Dr. Ambinder from December 9, 2003, December 23, 2003, October 19, 2004, and November 9, 2004, giving a variety of reasons for hyponatremia including ADH secondary to head trauma. On December 23, 2003, it was noted that the patient was requested to come in to be evaluated for critical values (page #443).

4. There are records from A. K. Choudhry, M.D. including notes of December 2, 2004 and October 10, 2005, with reference made to the new diagnosis of chickenpox on October 10, 2005. The diagnosis of chicken pox and erlichiosis was made on November 18, 2003 (#330). Also notes that he has hyponatremia receiving sodium supplements and was getting Lasix based on the notes of December 2, 2004.

5. There is a record from the Arthritis Associates, Dr. Jerry A. Green, which notes a history of multiple car accidents including an episode in 1998 when his car hit a deer and he had loss of consciousness. Abnormal speech patterns developed at that time with short-term memory loss with many brownouts noted. Eight month of cognitive therapy was given, also noted is a second car accident in 2000 where he hit an embankment; there was head trauma with no loss of consciousness. It should be noted that his speech remained abnormal and then in September of 2003, he was hit on the head by a galvanized pipe that fell from a door at work; by the next day, he noted dizziness, vertigo, headache, and nausea. He noticed that on one occasion, he was spinning around, sensitive to light, and this developed gradually. He could not recall any loss of consciousness. He stated that he had woken up on the floor unsure if he was just dazed or whether he had a loss of consciousness. (476-479).

6. There is a mention of a CAT scan, in a letter from Thomas Lansen, MD to Jeffrey Ambinder, MD dated February 23, 2004, which showed scar tissue in the frontal lobe (the Medical Board notes no documentation of scar tissue in the frontal lobe or on any CAT scan that it has record of and also notes subsequent MRIs that do not confirm this). There is also a history of thrush and protracted varicella during this episode. It should be noted that he has a complex clinical history with multiple concussions, nausea, dizziness, fatigue, musculoskeletal pains, weight loss, positive ANA, hyponatremia, hypoglycemia, increased cortisol levels, mild anemia, and occasional leukopenia with a history of high fluid intakes in the past and he is on fluid restriction. He felt there was probably multifactorial illness going on including postconcussive syndrome. There is also hypercortisolemia of unclear cause, causing hyponatremia and also noting a low glucose rather than high glucose, as one would expect with elevated cortisol levels. No source for the elevated cortisol has been found despite the work-up (page #651 and #652).

7. There is also history and physical evaluation dated October 26, 2004 from the Hudson Valley Hospital. The records indicate that the patient developed modest lethargy and decreased energy in the summer of 2003 (page #926 to #929). There is a note from Dr. Jeffrey Ambinder noting that in the summer of September 2003, the patient received a course of doxycycline for suspected ehrlichiosis and in October of 2003, the patient had

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chickenpox and in the summer of 2003, the patient received a course of antifungal oral medication with thrush. He notes that he was hit on the head with a pipe on September 22, 2003 and then he had low sodium since the end of September 2003. Diagnoses given were severe hyponatremia, history of head trauma, history of exposure to toxins, macrocytic anemia, and leukopenia (reference 926 to 929 by sequence, copy did not have number.)

8. On October 26, 2004, there is a record of a consultation by Dr. Coffino noting a recent diagnosis of Cushing's disease, traumatic brain injury on multiple occasions, the most recent one being greater than a year ago, and numerous episodes of hyponatremia. Admission for severe hyponatremia with the diagnosis of SIADH (syndrome of inappropriate antidiuretic hormone) secondary to brain trauma was given (930-932).

9. The Medical Board reviewed in detail the testimony of Dr. Ranada. It would appear that the diagnosis made by Dr. Ranada was based on a history of head trauma being more severe than documented by the contemporaneous records. It was discussed that the applicant was able to deny the loss of consciousness and there is reference made to him refusing aid by emergency medical services and going home by taking the train. This contradicts the mechanism of injury stated by several of his treating physicians used to make the diagnosis of SIADH related head trauma, including the history available to our consultant. Additionally excellent commentary remains with regards to the lack of retrograde and anterograde amnesia, which are conditions indicative of severity of head trauma. Based upon the lack of retrograde and anterograde amnesia, and lack of loss of consciousness, the point was brought up that the head trauma was not significant. (#1 - 190). Additional testimony indicated that any cognitive deficit preceding the incident in 2003 could be aggravated by hyponatremia and hypoglycemia.

10. On September 23, 2003, Dr. Chaudhry noted a small swelling over the occiput only. At that time, it stated that there was no dizziness. More significant was the complaints made of swelling in the legs and ankles. Reference was again made to (page #410).

11. Also submitted are records from New York Diabetes Center, which include documentation of hypertestosteronism and decreased energy (pages #677 to #687). There is a letter from Dr. Jerry Kleinbaum noting his sodium level remains 120 and it correlates best with the complaints of weakness and fatigue. He notes that the possible diagnosis of cortisol resistance is theoretical and he continued to treat him for posttraumatic SIADH.(#632)

12. Hudson Valley ER records for date of service 10/26/04, notes head trauma, but also presents a history of exposure to 9/11/01 and "states since then has been having different medical issues including anemia and hyponatremia of unexplained etiology."

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FINDINGS AND CONCLUSIONS

The Medical Board notes that there is no medical documentation submitted that precludes this applicant from being interviewed and examined by the Board.

There is sufficient laboratory documentation to conclude that Officer Bruno remains disabled from hyponatremia and a multitude of symptomatology at this time.

Given his history of low white blood cell counts, anemia and infectious diseases including thrush, and some indications on the record that his complaints pre-existed the incident by almost 2 years, the question is raised of whether the applicant has been worked up adequately with regard to conditions causing autoimmune deficiency. Specifically, no mention has been made of the applicant's HIV status.

The record raises the possibility of exposure at 911 to be a factor. The Medical Board raises the issue if disability benefits have been applied for these disease processes related to 911.

The Medical Board also has no clear record of all medications taken by the applicant.

The Medical Board also questions whether any additional testimony in addition to Dr. Ranada exists.

The Medical Board finds ongoing evidence of abnormalities in neurological and laboratory tests preceding the incident of September 22, 2003. It should be noted that the applicant has documented speech and cognitive disabilities preceding the incident of the September 22, 2003 based upon documents preceding and following the incident. In addition, he appears to have gone back to work in 2000 following his off duty incident with some speech difficulties.

The Board also notes two automobile accidents following the 1998 incident, which were off duty both resulting in head injuries and far more severe than the trauma of September 22, 2003 which based upon contemporaneous documentation was not consistent with trauma inducing closed brain injury.

The Medical Board notes that following initial evaluations by Datalr Rehabilitation following the off duty 1999 incident; there has been no subsequent evaluation submitted to the Medical Board. Therefore, the degree of "cognitive dysfunction" at this time is unknown. The residual degree of disability following his return to work in 2000 is unknown but obviously pre-existed the incident of 2003. This is based upon statements in the record and subsequent two additional significant head injuries preceding the incident of September 22, 2003.

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In addition, the Medical Board notes laboratory abnormalities including low sodium preceding the documentation of hyponatremia on September 27, 2003 wher the sodium was 132 on May 9, 2002. The Medical Board also notes evidence of hypotestosteronism (hypogonadism) with a low testosterone level on September 18, 2003 and also documentation by his internist and that he was given Viagra preceding the event. He also noted a febrile illness (fever) as early as of September 6, 2003, and then the febrile illness when the applicant presented to the hospital on September 27, 2003. This is all indicative of ongoing process, which started preceding the incident of September 22, 2003. The Medical Board also notes that a febrile illness is not the sequela of closed head trauma in a conscious patient.

The Medical Board is in agreement with Dr. Alan Jacobs that the episode of head trauma was too mild to cause anything like a fluid electrolyte disorder, namely symptoms of inappropriate antidiuretic hormone secondary to head trauma noting the laboratory results are not consistent with such diagnosis. In addition, we note that the letter by Dr. Jerry Kleinbaum dated August 5, 2005, notes that the possibility of cortisol resistance remains a theoretical consideration.

The Medical Board also notes that contemporaneous documentation, and testimony by Dr. Ranada indicates that the head trauma was not the type to induce SIADH, and that there was significant magnification of the degree of head trauma following the incident which appears to be the basis of SIADH induced head trauma as a diagnosis invoked by several physicians.

In summary, the Medical Board notes the following: Daniel Bruno is disabled from performing his duties of a Police Officer with Metropolitan Transportation Authority with the diagnoses of hyponatremia and cortisol resistance. It also appears that Mr. Bruno has an unknown degree of cognitive deficit.

The Medical Board finds ample documentation that his cognitive deficits pre-existed the incident of September 22, 2003 noting documentation of deficits while returning at work in 2000. The record indicates he suffered two additional off duty head injuries preceding the September 22, 2003. The allegation that the head injury sustained upon on September 22, 2003 causing any increase in deficits, it appears unfounded by the Medical Board noting however, that the episodes of hypoglycemia and hyponatremia may aggravate the cognitive deficiencies, but are not the result of the head trauma. This was also brought up in the testimony by Dr. Ranada.

We note evidence of laboratory abnormalities and a febrile illness preceding the mild head trauma of September 22, 2003. There is a clinical course including the lack of anterograde and retrograde amnesia and the ability to continue functioning immediately after the incident (the applicant refused EMS assistance, organized picture taking of the incident and took the train home on his own that day) which indicate that this type of trauma of is not consistent with causing SIADH. The Medical Board, agreeing with Dr. Jacobs, also finds that the laboratory abnormalities are consistent with cortisol resistance.

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Therefore, the final causation of Mr. Bruno's disability was not the incident of September 22, 2003 and the Medical Board recommends denial of his application for Accidental Disability Retirement.

The Medical Board also notes its request for further documentation and answers to questions raised in the introductory paragraph of this conclusion including immunodeficiency work-up, records of treatment and application for disability under the World Trade Center and a clear record of medications taken by the applicant over the course of the last three years. As previously noted, there is no record that indicates the applicant is unable to appear for an interview.

Sincerely,

Merritt Hait, MD
CHD Meridian Healthcare

Joseph Bottner, MD
Metropolitan Transportation Authority

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